

Informed Consent for Exfoliation Treatment(s)



I, _____ authorize _____ of (Business name) _____ to perform the marked exfoliation

Treatment(s):

- | | |
|---|---|
| <input type="checkbox"/> Lactic Acid Resurfacer [30%] | <input type="checkbox"/> TCA [30%] |
| <input type="checkbox"/> Glycolic Acid Resurfacer w/ Stem Cells [30%] | <input type="checkbox"/> Firming Enzyme Treatment |
| <input type="checkbox"/> Glycolic Acid Resurfacer w/ Stem Cells [40%] | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Glycolic Acid Peel w/ Stem Cells [70%] | <input type="checkbox"/> Modified Jessners |
| <input type="checkbox"/> Primary Pumpkin Resurfacer | <input type="checkbox"/> Traditional Jessners |
| <input type="checkbox"/> Power Pumpkin Resurfacer | <input type="checkbox"/> SkinBrite |
| <input type="checkbox"/> Salicylic Acid Resurfacer [20%] | <input type="checkbox"/> Salicylic Acid [30%] |
| <input type="checkbox"/> Primary Alpha Peptide Resurfacer | <input type="checkbox"/> MicroRoller |
| <input type="checkbox"/> Power Alpha Peptide Resurfacer | |
| <input type="checkbox"/> TCA [7%] Salicylic Acid [2%] | |

Initial

____ 1. I acknowledge that I have properly balanced my skin prior to obtaining the exfoliation treatment listed above. I used the following skin care regimen:

I am Fitzpatrick 1-3 and I used option _____ for 2 weeks prior to my exfoliation treatment

I am Fitzpatrick 4-6 and I used option _____ for 4 weeks prior to my exfoliation treatment

OPTION 1

Pre-Treatment Home Care Program:

- Daily Enzyme Cleanser
- Advanced B5 Serum
- Revive Cream
- ZinClear SPF 30

OPTION 2

Balancing Kit plus tyrosinase inhibitor (SkinBrite Cream / Serum or HydroBrite)

____ 2. I acknowledge no guarantee has been made about the results of the procedure. Although it is impossible to list every potential risk and complication, I have been informed of the possible risks and complications which may include, but are not limited to, the following:

- Stinging, itching, irritation
- Redness and swelling of the skin
- Tightness, peeling or scabbing of treated skin and the surrounding areas
- Prolonged skin sensitivity to wind and such environmental elements

____ 3. Any potential risks and complications could result in the need to discontinue the treatment. In this case, alternative recommendations(s) will be suggested. It is very rare that a permanent disability occurs. If the need arises, I authorize my esthetician or physician to perform such required treatment or procedure. I also agree to immediately inform the esthetician or physician if I have concerns, or am overly uncomfortable during the treatment, or after I return home.